REQUEST FOR INTRA-STATE ASSISTANCE

Please complete the following information. Incomplete/missing information will delay response.

RECEIVING AGENC	CY:		SENDING AGENCY:			
ADDRESS:			SENDING PRIMARY WOR	RKER:		
ATTENTION:			PRIMARY WORKER PHO	NE:		
			PRIMARY WORKER EMA	AIL:		
	on.					
ATTACHMENT						
COURT ORDER	□CASE PLAN	□SUBSTANCE ABUSE EVAL □ IEP		_		
☐ COURT REPORT	SAFETY ASSESSMENTS	☐ MENTAL HEALTH/ PSYCHOLOGICAL ☐ OTHER		☐ OTHER		
	☐ SOCIAL SUMMARY	ASSESSM	ENTS			
SECTION 1. DE						
SECTION 1: RE	CCT ALL THAT APPLY)					
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	Y HOME VISTS OME, HOME STUDY		☐ FOSTER PLACEMENT (HIGHER LEVEL OF CARE) ☐ FOSTER PLACEMENT (NON-KIN OR FICTIVE KIN)			
☐ RELATIVE	HOME STUDY	☐ COORD	☐ COORDINATE LOCAL SERVICE DELIVERY			
□ADOPTIVE	HOME STUDY	☐ SUPERVISE FAMILY VISITS ☐OTHER:				
		_OTHER:	·			
IIICII DDIODITA	DECLIECT					
HIGH PRIORITY EXPLAIN (PL	REQUEST EASE ATTACH ALL RELE	VANT DOCI	UMENTS)			
2311 23111 (1 2		VIII (1 DOO)				

NEXT COURT DATE CONCERNING THIS REQUEST:

SECTION 2: FAMILY AND CASE INFORMATION

ce: Statewide Policy Manual Subject: INTRA-STATE COURTESY SUPERVISION

CASE NAME UNITY CASE # ICWA APPLICABLE Y N IF CASE IS APPLICABLE FOR THE INDIAN CHILD WELFARE ACT PLEASE PROVIDE THE FOLLOWING INFORMATION: TRIBAL AFFILIATION: HAS TRIBE BEEN NOTIFIED OF CUSTODY? TRIBAL SOCIAL WORKER: TRIBE NOTIFIED OF PLACEMENT CHANGE? ☐ Y ☐ N TRIBAL MEMBERSHIP CONFIRMED? TRIBAL SOCIAL WORKER TELEPHONE # IS PROPOSE PLACEMENT ICWA COMPLIANT? TRIBAL CONTACT ADDRESS: \square Y \square N WHAT SERVICES ARE PROVIDED TO MAINTAIN CULTURAL CONNECTION? MOTHER'S INFORMATION MOTHER'S NAME: TERMINATION OF PARENTAL RIGHTS: ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N DATE OF TPR PHONE: LAST KNOWN ADDRESS: VISITATION PLAN/AGREEMENT ESTABLISHED (IF YES PLEASE EXPLAIN) FATHER'S INFORMATION FATHER'S NAME: TERMINATION OF PARENTAL RIGHTS: \square Y \square N \square Y \square N PHONE: DATE OF TPR \square Y \square N LAST KNOWN ADDRESS: VISITATION PLAN/AGREEMENT ESTABLISHED (IF YES PLEASE EXPLAIN) REMOVAL CAREGIVERS (IF NOT PARENTS) RELATIONSHIP TO CHILD(REN) VISITATION PLAN/AGREEMENT ESTABLISHED $\prod Y \prod N$ NAME: (IF YES PLEASE EXPLAIN) PHONE: LAST KNOWN ADDRESS: REMOVAL CAREGIVERS (IF NOT PARENTS) RELATIONSHIP TO CHIL(REN) NAME: VISITATION PLAN/AGREEMENT ESTABLISHED \square Y \square N (IF YES PLEASE EXPLAIN) PHONE: LAST KNOWN ADDRESS:

Subject: INTRA-STATE COURTESY SUPERVISION

SECTION 3: CHILD AND PLACEMENT INFORMATION (attach more sheets if necessary)

ARE ALL CHILDREN TO BE PLACED AT THE SAME LOCATION? $\ \square$ YES $\ \square$ NO

CHILD NAME: UNITY PERSON # PERMANENCY GOAL DATE OF MOST RECENT REMOVAL			IEI	DOB: MALE FEMALE IEP Y N LEGAL STATUS			
CURRENT SERVICES (i.e. mental heal	lth, substance	e abuse treatment, P	SR, BST	etc.)			
NON-COVERED SERVICES:			ANTICIPATED COST:				
SPECIAL NEEDS (i.e. pregnant, medically fragile etc)							
PROPOSED PLACEMENT DATE			PROPO	PROPOSED PLACEMENT ADDRESS			
NAME (CAREGIVER)	1		NAME (2 ND CAREGIVER)				
DOB	SSN		DOB	Ì	SSN		
RELATIONSHIP TO CHILD	1		RELAT	TIONSHIP TO CHILD		l	
WORK#	CELL#		WORK:		CELL#		
		BEST T	BEST TIME TO CONTACT EMPLOYER:				
OTHER ADULTS IN HOME (OVER 18)		DOB		SSN	RELATION	NSHIP TO CHILD	
PROPOSED PLACMENT DURATION:							
APPROVED				DENIED			
PLEASE EXPLAIN RATIONALE FOR DENIED PLACEMENT							

CHILD NAME:				DOB:			
UNITY PERSON #				MALE FEMALE			
PERMANENCY GOAL				P Y N			
DATE OF MOST RECENT REMOV	AL		LE	GAL STATUS			
CURRENT SERVICES (i.e. mental heal	th, substance	e abuse treatment, PS	SR, BST	etc.)			
,			,	,			
NON COMEDED SERVICES			4.3	TELCUDATED COST			
NON-COVERED SERVICES:			ANTICIPATED COST:				
SPECIAL NEEDS (i.e. pregnant, medica	ally fragile et	tc.)					
PROPOSED PLACEMENT DATE			PROPO	SED PLACEMENT ADDRE	SS		
YYY CARROWER)			AND GUARDOWERD				
NAME (CAREGIVER)	~~~			(2 ND CAREGIVER)			
DOB	SSN		DOB		SSN		
RELATIONSHIP TO CHILD				TONSHIP TO CHILD			
WORK#	CELL#		WORK	#	CELL#		
BEST TIME TO CONTACT EMPLOYER:			BEST TIME TO CONTACT EMPLOYER:				
DESTRUE TO CONTINUE EMPLOYER.			DEST .	TIME TO CONTINUE EMILE	, I LIK.		
OTHER ADULTS IN HOME (OVER 18)		DOB		SSN	RELATIONSHIP TO CHILD		
PROPOSED PLACMENT DURATIO	N.						
APPROVED					DENIED		
PLEASE EXPLAIN RATIONALE FOR DENIED PLACEMENT							

PROPOSED PLACMENT DURATION:

Subject: INTRA-STATE COURTESY SUPERVISION **CHILD NAME:** DOB: \square MALE \square FEMALE **UNITY PERSON #** IEP Y N PERMANENCY GOAL DATE OF MOST RECENT REMOVAL **LEGAL STATUS** CURRENT SERVICES (i.e. mental health, substance abuse treatment, PSR, BST etc.) NON-COVERED SERVICES: ANTICIPATED COST: SPECIAL NEEDS (i.e. pregnant, medically fragile etc.) PROPOSED PLACEMENT ADDRESS PROPOSED PLACEMENT DATE NAME (2ND CAREGIVER) NAME (CAREGIVER) SSN DOB DOB SSN RELATIONSHIP TO CHILD RELATIONSHIP TO CHILD WORK# WORK# CELL# CELL# BEST TIME TO CONTACT EMPLOYER: BEST TIME TO CONTACT EMPLOYER: OTHER ADULTS IN HOME (OVER 18) DOB RELATIONSHIP TO CHILD SSN

APPROVED	DENIED				
PLEASE EXPLAIN RATIONALE FOR DENIED PLACEMENT					

Subject: INTRA-STATE COURTESY SUPERVISION

SECTION 4: ASSISTANCE APPROVED DESCRIPTION OF SERVICES TO BE PROVIDED E (CHECK ALL THAT APPLY)	BY RECEIVING AGENCY
☐ COURTESY HOME VISTS ☐ ☐ FOSTER HOME, HOME STUDY ☐ ☐ RELATIVE HOME STUDY ☐ ☐ ADOPTIVE HOME STUDY ☐	FOSTER PLACEMENT (HIGHER LEVEL OF CARE) FOSTER PLACEMENT (NON-KIN OR FICTIVE KIN) COORDINATE LOCAL SERVICE DELIVERY SUPERVISE FAMILY VISITS OTHER:
NAME TELEPHONE EMAIL	SUPERVISOR'S NAME SUPERVISOR'S EMAIL
APPROVING PARTY SIGNATURE:	
NAME: TITLE:	SIGNATURE: DATE: